STATE MEDICAID P&T COMMITTEE MEETING

**THURSDAY, October 18th, 2012**

**7:00 a.m. to 8:30 a.m.**

**Cannon Health Building**

**Room 114**

# MINUTES

**Committee Members Present:**

Ellie Brownstein, M.D.
Kort Delost, R.Ph.
Lisa Hunt, R.Ph.
Beth Johnson, R.Ph.
Julia Ozbolt, M.D.
Roger Martenau, M.D.

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**Dept. of Health/Div. of Health Care Financing Staff Present:**

Tim Morley, R.Ph.
Robyn Seely, Pharm.D.
Rick Sorenson, R.N.
Heather Santacruz, R.N.

**University of Utah Drug Information Center Staff Present:**

Melissa Archer, Pharm.D.
Gary Oderda, Pharm.D.

**Other Individuals Present:**

Scott Larson, BMS
Lori Howarth, Bayer
Mark Germann, Novartis
Scott Clegg, Lilly

Meeting conducted by Ellie Brownstein

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1 Review and Approval of Minutes: Ellie Brownstein moved to accept the September meeting minutes. The motion was seconded by Kort Delost. The motion passed unanimously.

2 Tim Morley offered a short explanation of the move to managed care, or Accountable Care Organizations (ACOs). The Utah Legislature passed a Bill in the last session (Spring 2012) requiring the adaptation of a managed care model for administrating medical benefits, including pharmacy benefits. This was in response to national legislation, the Affordable Care Act (ACA). The ACOs in Utah will principally be in the four major metropolitan counties: Utah, Salt Lake, Davis, and Weber. Medicaid currently has managed care in these areas, but pharmacy benefits have been administered outside of managed care. This has been referred to as "carved out". Pharmacy benefits will now be part of managed care. 200,000 patients will move into ACOs, leaving 50,000 to 100,000 patients in fee-for-service (FFS) pharmacy benefits, as they currently are.

Medicaid is legislatively prohibited from managing some classes of drugs, and these classes will continue to be excluded from managed care. These categories are drugs used to treat drug and alcohol abuse, hemophilia, drugs used for the prevention of organ rejection following transplantation, and mental health drugs. The mental health drugs are antipsychotic, antidepressant, anticonvulsant and antianxiety drugs, as well as stimulants (e.g. those used to treat ADHD). They will continue to be paid via the FFS model, for all patients, whether or not they are enrolled in an ACO. The ACOs will not manage these drugs, and will not be able to restrict or "not prefer" any of these drugs. In addition, substance abuse treatment programs remain outside of the ACOs, so drugs used to treat substance abuse remain un-managed, or "carved out".
The ACOs will go into effect on January 01, 2013. There are four managed health care plans. The Pharmacy and Therapeutics (P&T) committee meetings will be presenting their plans during November and December's P&T meetings. They will present their plans for transitioning patients from FFS to their ACO. They will also present proposed Preferred Drug Lists (PDLs), methods for determining preferred and non-preferred drugs. Medicaid has provided the ACOs our PDL, and each ACO chooses its own PDL which may match or may be very different from Utah Medicaid's. Medicaid has provided the ACOs with a list of the very few drugs that are not rebateable, but that Medicaid covers. Tim asks the P&T committee to make every effort to attend the committee's November and December meetings. He thanked them for their time and efforts.

a. Questions and Answers:
    i. (Unidentified audience member): How will patients in the four counties go about selecting an ACO? Most patients are already enrolled in an ACO that manages their medical benefits. Unless a patient proactively chooses otherwise, they will be default enrolled in the same ACO for their pharmacy benefits. The open enrollment period is October 15th 2012 to Novbmer15th, 2012. If a patient does not currently have managed medical care, and does not make a selection during open enrollment, they are randomly assigned to an ACO. A patient also has 90 days after January 1st, 2013 to opt-out and change to a different ACO.

3 Lisa Hunt explained that two ACOs will present a high level overview in November, and two in December. Lisa will present the P&T's past recommendations alongside the ACO's submitted PDL, so the Committee can more easily review, compare, and ask questions. The ACOs first approached the Drug Utilization Review Board (DURB) as an audience for their presentations, but the DURB delegated to task to the P&T Committee. The P&T Committee is a sub-committee of the DURB, and so can be delegated to. The subject matter is also better tailored to the P&T Committee, which is the steward of Medicaid's PDL. The delegation was unanimously approved by the DURB in a previous meeting.

a. Questions and Answers:
    i. Beth Johnson: A patient will receive most drugs through their ACO, but if the patient takes a mental health drug, that will still be FFS. Will the patient have two different identification cards? Yes. Medicaid will still

send monthly eligibility cards, which will include their ACO information. ACOs may or may not choose to issue their own additional cards. It is important that pharmacies contact the four plans to ensure that they are in contract with one another. This will avoid the possibility of a patient continuing to get mental health drugs at pharmacy X, which does not have a contract with that patient's ACO, and get their other drugs at pharmacy Y, which does have a contract with that patient's ACO.

ii. Beth Johnson: Is it going to be the responsibility of the pharmacist to determine which drugs need to be submitted to which plan (FFS or ACO)? Medicaid has instructed the ACOs the contact pharmacies. Medicaid will provide messaging via the point of sale instructing the pharmacist to bill the ACO. This message will contain the name of the applicable ACO and the BIN and ID number. Medicaid is publishing an Amber sheet with ACO information. Lisa Hunt will be a presenter at November's Utah Pharmacist's Association meeting, and will discuss ACOs.

iii. Julia Ozbolt: Will there be any guidance to prescribers, to help them know what to prescribe, so they don't keep inadvertently prescribing drugs that require prior authorizations? Each ACO is required to have a website with their PDL.

iv. (Unknown audience member): How many plans are there? Four: Molina, Healthy U, Select Health, and Health Choice. Recall that there will still be Traditional, and Non-traditional, as well as Traditional Nursing Home patients for up to 30 days, allow a theoretical 12 different PDLs. Also recall that Primary Care Network (PCN) benefits will continue as FFS.

v. Beth Johnson: Can patients in the four counties choose to be FFS, or do they have to go to managed care? They have to go to managed care. After enrolling, there may be up to 60 days before a patient in enrolled in an ACO, so there will still be a few transient FFS patients in the four counties. In addition, if a patient moves from one of the four counties into a rural county, they will not be required to, but certainly can, remain enrolled in an ACO. So there will be a few non-ACO-enrolled patients in the four counties, and a significant amount of ACO-enrolled patients outside the four counties.

vi. (Unknown audience member): Does Medicaid have data regarding drug use among the managed care plans? For example, can Medicaid provided data regarding the use of antihypertensive among patients in an ACO? The ACOs must report all there drug utilization data to Medicaid for analysis. Medicaid is still considered the "medical home". This type of information is stored in our data warehouse. We call this "encounter data", or "encounter claims".

vii. Beth Johnson: Part D information exchanges include cost and reimbursement information. Will ACOs and Medicaid communicate in a similar way? Medicaid calls this "per-member-per-month per deim rate", and is included in the information exchanged (see above). If an ACO

chooses to cover a non-rebateable drug, that drug is not included in the per-member-per-month per diem rate. This information is used in manufacturer billing and rebate collection.

viii. (Unknown audience member): Will the DURB continue to function? Yes. According to Federal statute, the state DURB programs must be maintained, and will continue their activities for the FFS portion of Medicaid. The Board will also oversee the ACOs, and can address points of concern with ACOs, levy sanctions, etc.

ix. (Unknown audience member): Other, non-Medicaid insurers also have rebate programs. Will the ACOs be expected to not collect those rebates? Is there anything to prevent double rebates? ACOs keep any rebates that ACOs have and collect on their own. Medicaid is responsible for collecting Federal rebates. There is nothing to prevent double rebates.

4 Lisa Hunt reported that she will meet with Michael Hales, Director of the Department of Health, later today (Thursday October 18th, 2012) to discuss and gain approval of 10 of the classes on the latest (Medicaid FFS) PDL.

5 Housekeeping: Lisa Hunt asked all Committee members and guests to sign in.

6 **Topical Corticosteroids, Melissa Archer, University of Utah**

a. Several chemical entities, dosage forms, and indications. Comparative potency was discussed. Clinical trials were discussed. The majority of studies are placebo-controlled, rather than head-to-head. Utilization data, including pediatric, was presented. Recommendations: include at least one ointment and one cream in each potency group, and at least one lotion or solution for use on the scalp. Lisa Hunt provided other states' PDL choices for reference. Lisa Hunt would like to receive a recommendation from the Committee, and then hopes to separate them, in a PDL listing, per strength.

b. No public comment

c. Bernadette Kiraly: What rectal products are available? Only over-the-counter cream is available, and so were not included in the recommendations.

d. Committee Discussion:

i. Ellie Brownstein moved that, within their class, the topical corticosteroids are equally safe and effective. The motion was seconded by Julia Ozbolt. The motion passed unanimously.

ii. Beth Johnson agrees with Melissa Archer's recommendation, and that the utilization data should guide decisions as to specific products to prefer. It was suggested that three or four potency categories be identified, and that each category contain at least two chemical entities and at least on lotion or other delivery system that is conducive for use on the scalp. The Committee deferred to Lisa Hunt to decide upon which drugs are in each potency category and delivery vehicles to include, using utilization data as a guide. Kort Delost suggested that triamcinolone be included, perhaps in

several potency categories, because of high utilization. Kort Delost moved according to the discussion, i.e. that there be at least 4 potency categories, each containing at least two chemical entities, a cream and an ointment, and when appropriate, a lotion or solution. If cost is prohibitive, gels, foams, and other dosage forms need not be preferred. The motion was seconded by Bernadette Kiraly. The motion passed unanimously.

iii. Utilization was discussed. Within the motion above, Ellie Brownstein motioned to include betamethasone, desonide, hydrocortisone, and triamcinolone, within their respective categories.

iv. Combination products were discussed, including antifungal/antibacterial combination products. General consensus was to exclude these products from the preferred drug list, preferring the single-ingredient products.

v. Rectal preparations were discussed. There is only one; hydrocortisone suppositories and rectal cream. Beth Johnson noted that these preparations do not have the same indication(s) as all the other products reviewed. Kort Delost moved that they should be preferred. Jameson Rice seconded. The approval was unanimous.

e. Summary of Board Discussion: Final Motions in identifying Preferred Products:

i. At least four strength categories

ii. At least two unique chemical entities in each category

iii. At least one cream and one ointment in each category

iv. Where appropriate, a lotion and/or solution and/or gel in each category

v. Based upon utilization data, desonide, betamethasone, hydrocortisone, and triamcinolone must be included in their appropriate category/ies

vi. Combination products are to be excluded from preferred status

vii. Motioned by Ellie Brownstein, seconded by Beth Johnson. The approval was unanimous.

The next Pharmacy and Therapeutics Committee meeting is scheduled for Thursday, November 15th, 2012.
Meeting Adjourned.
Minutes prepared by Robyn Seely.